

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 01/17/12

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: Appeal Individual Psychotherapy 1x6 Lumbar  
90806

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER  
HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Texas Board Certified Psychologist

**REVIEW OUTCOME**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Cover sheet and working documents
2. Utilization review determination dated 10/31/11, 12/20/11
3. Reconsideration dated 11/30/11
4. Letter dated 12/29/11
5. Post designated doctor RME dated 12/07/10
6. Fax cover sheet dated 12/17/10
7. Treatment reassessment summary dated 11/18/11
8. Initial behavioral medicine consultation dated 10/17/11
9. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a male whose date of injury is xx/xx/xx. On that date, the employee was cleaning out a warehouse when metal started to fall off of the forklift. The employee tried to rebalance the metal and heard a pop in his back followed by pain.

Post designated doctor Required Medical Evaluation (RME) dated 12/07/10 indicated that the employee's past surgical history was significant for ankle surgery in 1978 and back surgery in 2008. Treatment to date was noted to include MRI, spine injections, work conditioning, trigger point injections, electrical stimulation, physical therapy, massage, chronic pain management. The employee had completed a 20 day chronic pain management program. The employee reports that he was seeing a counselor through Department of Assistive and Rehabilitative Services trying to deal with everyday stuff, but it had not helped him stop his worrying. He had 4 out of 8 positive Waddell's tests which is significant for symptom magnification. BDI was 35 and BAI was 29. Diagnoses were bipolar disorder depressed; rule out major depressive disorder with psychotic features; methamphetamine dependence in remission; benzodiazepine dependence. MMI date is noted as 05/27/10. There was no mental and behavioral impairment if MMI is at 05/27/10 because there were no psychiatric symptoms at that point in time based on the history and on the medical records. Psychiatric symptoms did not show up until about a month before surgery by the claimant's history which would be about 2 or 3 weeks after date of MMI. Initial behavioral medicine consultation dated 10/17/11 indicated that medications include Cymbalta, Clonazepam and Ambien. The employee reported that he had severe bouts of depression due to failed back surgery. He was hospitalized for one to one and one-half weeks due to suicidal ideation after his surgery. No current suicidal ideation or plan reported. The employee did not receive individual psychotherapy in connection with workers compensation, but had vocational counseling through DARS. BDI is 43 and BAI is 24. Diagnoses were pain disorder associated with both psychological factors and a general medical condition; and major depressive disorder, recurrent, severe, without psychotic features. Treatment reassessment summary dated 11/18/11 indicated that the employee had completed four sessions of individual psychotherapy. FABQ scores were unchanged. Pain has decreased from 3/10 to 1/10; irritability 6/10 to 1/10; frustration 2/10 to 1/10; muscle tension 4/10 to 2/10; anxiety and depression remain 1/10; sleep problems decreased from 4/10 to 1/10. Current BDI was 0 and BAI was 2

The initial request for individual psychotherapy 1 x 6 was non-certified on 10/31/11 noting that the employee had schizophrenia. The employee has had 20 sessions of chronic pain management program, 9 sessions of individual psychotherapy and 11 mental health visits; however, the employee continued to experience pain. Factors that deter progress despite previous treatments and specific course of action to address these were needed to be clarified. Reconsideration dated 11/30/11 indicated that nowhere in the report did it mention that the employee had schizophrenia. It is unknown where the peer reviewer obtained that information. It is unknown when and where the employee participated in a chronic pain program or benefit of this program he derived. He denied having received low level counseling for this injury. The denial was upheld on appeal dated 12/20/11 noting that the employee has undergone prior psychological treatment to include 20 sessions of a chronic pain management program. No prior treatment notes were submitted for review to note the date of service as well as the efficacy of care. **Official Disability Guidelines** does not recommend reenrollment in similar programs after completion of a chronic pain management program. It was noted

that individual psychotherapy was included in the prior completed chronic pain management program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Based on the clinical information provided, the request for individual psychotherapy 1 x 6 lumbar is not recommended as medically necessary. The employee has undergone previous psychological treatment to include 20 sessions of chronic pain management program as well as 4 recent sessions of individual psychotherapy. There are no progress notes from the chronic pain management program submitted for review to establish the employee's objective, functional response to this program. Treatment reassessment note dated 11/18/11 indicates that the employee does not present with significant depression or anxiety as BDI is 0 and BAI is 2. FABQ scores were unchanged despite individual psychotherapy. The Official Disability Guidelines support up to 13-20 sessions of individual psychotherapy with evidence of objective functional improvement. Given the employee's lack of significant progress with treatment completed to date and the employee's lack of significant psychological factors, the requested individual psychotherapy is not indicated as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

**1. *Official Disability Guidelines, Mental Illness and Stress Chapter***

Cognitive therapy for depression	Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). ( <a href="#">Paykel, 2006</a> ) ( <a href="#">Bockting, 2006</a> ) ( <a href="#">DeRubeis, 1999</a> ) ( <a href="#">Goldapple, 2004</a> ) It also fared well in a meta-analysis comparing 78 clinical trials from 1977-1996. ( <a href="#">Gloaguen, 1998</a> ) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. ( <a href="#">Thase, 1997</a> ) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ( <a href="#">Corey-Lisle, 2004</a> ) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. ( <a href="#">Pampallona, 2004</a> ) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. ( <a href="#">Royal Australian, 2003</a> ) The gold standard for the evidence-based treatment of MDD is a combination
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	<p>of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (<a href="#">Warren, 2005</a>)</p> <p><b>ODG Psychotherapy Guidelines:</b> Initial trial of 6 visits over 6 weeks With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)</p>
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